South Carolina Department of Health and Human Services

APPLICATION FOR TEFRA MEDICAID COVERAGE Date Received by DHHS:

1. Name of Child (the Applicant) applying for Medicaid:

Last Name:	First Name:	Middle Initial:	Telephone:
Birth Date:	SSN:	Sex:	Place of Birth (city, county, & state):
Mother's Full Maiden Name	Tell us what language you use most: ☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Sign Language ☐ Vietnamese ☐ Other		
Race: ☐White ☐African American ☐ Mexican ☐ Native American/American Indian ☐ Puerto Rican ☐ Cuban ☐ Hispanic ☐ Asian ☐ American/Oriental ☐ Refugee Entrant ☐Other			

2. Applicant's Address:

Street Address:	City:	State: SC	Zip Code:	County:
Mailing Address, if different:	City:	State: SC	Zip Code:	

3. Parent(s) or Guardian(s) of the Applicant:

Last Name:	First Name:	Middle Initial:	Relationship to the Applicant:

4. (a) Does the Applicant have income from any source listed below? *(Check Yes or No)*

Income Source	Yes	No	Income Source	Yes	No	Income Source	Yes	No
Social Security			Money from Friends or Relatives			Other (Identify Source)		
Veteran's Benefits			Interest, Dividends					
Child Support			Income from a Trust					

(b) If the Applicant receives income from any of the sources listed in Section 4(a), complete the following and provide proof of the income:

Name of Person with Income Source	Income Source [as listed in 4(a)]	Amount	How Often Received

5. (a) Does the Applicant have any of the following assets/resources? *(Check Yes or No)*

Item	Yes	No	Item	Yes	No	Item	Yes	No
Cash on Hand			Preneed Burial Contract			Trust Account		
U.S. Savings Bonds			Trust Fund			Annuity		
Stocks and Bonds			Checking or Savings Account			Life Insurance		
Certificate of Deposit			Other					

(b) Fill in the following information for any item checked "yes" in Section 5(a) and provide proof of the assets/resources.

Item [*as listed in 5(a)]*	Amount/Value	Owned By	Name and Address of Bank or Location of Account

6. Is there any asset/resource available to the Applicant that we have not asked about? ☐ Yes ☐ No

If yes, please explain: _____

_____

7. Does the Applicant have health insurance? ☐ Yes ☐ No **If yes, please complete the following and provide a copy of the insurance card:**

Insurance Company or Employer	Policy Number	Policyholder's Name	Policyholder's SSN

8. Did the Applicant receive medical services in the last three months? ☐ Yes ☐ No **If yes, which months?**

_____

9. Were the Applicant's income and resources the same in the last three months as now? ☐ Yes ☐ No

If no, explain how they were different: _____

_____

10. Does the Applicant for whom you are applying have a plastic South Carolina Partners for Health (Medicaid) card? ☐ Yes ☐ No

Children under the age of 21 who are eligible for Medicaid may have free health checkups under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Ask your primary care physician about these services.

All Medicaid beneficiaries may be eligible for help with medical transportation. Ask your Medicaid eligibility worker about transportation services.

11. I have read my Rights and Responsibilities on the next page. ☐ Yes ☐ No

Signature of Applicant, Parent or Legal Guardian:		Date:
Signature of Responsible Person or Authorized Representative:	Title/Relationship:	
Address:		Date:
Witness (signature by a mark "X" requires two witnesses):	Witness:	Date:

RIGHTS AND RESPONSIBILITIES

1. I know that my children under age 19 who are eligible for Partners for Health Medicaid can have free health checkups under a special prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

2. I know that the information I have given is confidential. I understand that, except as specified below, information including medical information can be released only for purposes directly related to the administration of the Medicaid Program. At times, the Department of Health and Human Services (DHHS) will release information to organizations that they hire to carry out specific purposes, but those organizations will have agreed to be bound by the same guidelines for release of information. Furthermore, I know that personal health information I provide or that is later gathered by DHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will be receiving a Notice of Privacy Practices along with my Medicaid Card(s).

   a. I know that, in accordance with the federal rules governing the Medicaid Program, any information I have given must be reviewed and verified by DHHS staff. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission by me is needed to get verification or other information.

   b. I know that, in accordance with the federal rules governing the Medicaid Program, DHHS staff must provide information about my family and me to a computer system called the State Income and Eligibility Verification System (IEVS). This computer system allows DHHS to compare the information about me and my family with information from other agencies, and allows other state (including agencies from other states) and federal agencies to use information gathered on this application to verify eligibility and determine benefit amounts for their programs. Other agencies include, but are not limited to, the Internal Revenue Service, Social Security Administration, and Employment Security Commission, other states' Medicaid programs, and the TANF and Food Stamp agency (DSS, in this state). Immigration status will be verified with the Department of Homeland Security (DHS).

   c. I know that, unless I specify otherwise, information about my family and me may be shared by DHHS for the purpose of making a proper referral of my case to other sources of services or treatment, in accordance with federal and state law. When possible, I, or my responsible party, will be asked to agree. However, I further understand that in the case of mandatory reporting, DHHS must report, and cannot honor my specification to the contrary.

   d. I know that, unless I specifically ask not to be included, information about services (including medical services) provided to my family and me will be stored in a data warehouse operated by the South Carolina Budget and Control Board, Office of Research and Statistics, and that other state agencies that provide services to me or my family will be allowed to access that information in order to be sure that services provided to my family and me are sufficient and necessary.

3. I know that my Social Security Number, which I am required to provide, under §1137(a)(1) of the Social Security Act [42 U.S.C. 1320b-7(a)(1)], may be used or released in connection with the exceptions in Item 2, above.

4. I know that according to Federal law and US Department of Health and Human Services (HHS) policy, DHHS cannot discriminate on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, I should contact HHS by writing to The HHS Director, Office of Civil Rights, Room 506F, 200 Independence Avenue, SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

5. I know that the Medicaid program does not pay medical expenses that a third party, such as a private health insurance company or someone who injures me, is supposed to pay. I therefore assign and give my rights to any payments from a liable third party to the DHHS up to the payment amount that Medicaid has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from hospital and health insurance policies or payments received as a settlement from an accident.

6. Completion of a Medical Support Referral Form is required on an absent parent(s) if the custodial parent/caregiver relatives want Medicaid coverage.

7. I understand that I must report any and all changes in my income, deductions, resources, living arrangements, members of the household, or other information that will affect medical help within ten (10) days of the date of the change(s). I understand that if I fail to notify the department promptly, I may lose benefits and be subjected to penalties or prosecution.

8. I know that I may request a hearing if I believe an error has been made in processing my application.